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HEALTH CARE SYSTEMS: OPPORTUNITIES AND CHALLENGES

by

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The need for creative collaboration between applied behavioral scientists and leaders of health education and delivery systems is growing at an alarming rate.

It is anybody's guess whether the resources of our field can be coupled to the health systems' needs fast enough to meet these needs appropriately.

While there is increasing awareness on the part of health leaders of their needs for help, there is also a large amount of mistrust and scepticism as to whether behavioral scientists can provide it.

For the past three years I have been working with a variety of change and development projects in the health field. These have included a program with deans of medical schools designed to help them manage the changes required by the changing roles and structures of health schools, and their relationships to universities, teaching hospitals and students. Another project is testing ways of introducing educational content on change management in a variety of health settings. I have also been working with some health centers on the organization problems around interdisciplinary team delivery of primary care. I have been teaching a course in "Self Management and Change" to a class of social medicine interns and residents.

In all these situations, I have found tremendous interest in the applications of behavioral science knowledge and technology to the problems of managing health education and delivery. I have also found tremendous suspicion and doubt about the practicality and relevance of this knowledge. This paper emerges from these experiences and from my

deep conviction of the high potential for synergy and social improvement, if we collaborate. It is my hope that it will provide some additional stimulation to colleagues, who are interested in working with health systems.

I do not propose to develop a prescription or even a strategy for intervention. Rather, I would like to share information and experience about:

- the needs of health systems leaders;
- some negative perceptions held by health workers and by behavioral scientists that are impeding collaboration;
- the environment around the health system today;
- some experiences in collaboration;
- and finally some thoughts about what interested behavioral science practitioners can do.

HELP!!!???

First, I want to describe briefly some categories of potential clients, and the kind of problems they are identifying.

1. Deans of Medical Schools and Academic Centers

The dean of an academic medical center today manages one of the most complex institutions in our society. He manages a series of basic science departments; clinical departments, whose heads also frequently serve as chiefs of services in the hospitals. He shares control of his resources with hospital administrators, department heads, and hospital staff. He is involved with a tremendous number of complex relationships -- with other health schools in the university, with university management, with the hospitals, with state and local legislatures, with funding sources, with government agencies of all kinds.

Here are a few specific areas where needs for help have been identified:

- How to develop better problem solving and collaboration among the disparate groups that make up the "management team" -- basic scientists, clinical department heads, hospital administrators, business managers?

- How to allocate the decision making, and design the organization structure to deal with the multiple and overlapping roles of many people in the center. How much should the organization be set up as it traditionally is on functional lines? When is a "mission" or "program" structure appropriate? When is a matrix organization required?

- How best to manage conflict which is built into the system because of the different goals and priorities; competition for shrinking funds, etc.

- How to maximize the effectiveness of meetings.

- How to deal with intergroup problems such as mergers; joint responsibility for students between school and hospital.

- How to manage the ambiguity caused by multiple reporting lines?

- How to handle the conflicts caused by changing demands from the environment. For example, if the center is to be more community oriented, should there be a Department of Community Medicine? If so, who has the power over the doctors who work there? -- The chiefs of pediatrics and internal medicine or the community medicine director?

2. Directors and Faculties of Other Health Schools

Leaders of nursing, dental, and allied health schools are concerned with many of the same things as medical school leaders. One specific issue is how to increase collaboration and interface with the medical school. One emerging issue is that many universities are creating a new role, frequently called Vice President of Health Affairs. This role has the line responsibility for all health schools. Issues developing from that include:

- How does decision making and power get distributed between that role and the deans of the schools? What is the dean's role?

How much interdependency is desirable? -- necessary? -- between the schools?

3.Hospital Administrators

Although hospital administrators have had, generally speaking, more management training; and tend to be more experienced in the management of complex organizations -- the emerging emphasis on community health care; new constraints on their freedom to manage their organization; the emergence of community health centers; the changing role of outpatient clinics -- all produce new problems requiring new skills. A list of their needs would be very similar to the medical school deans'.

4.Community Health Center Directors

This is a new breed of community oriented primary care oriented institution manager. Usually, they have limited experience in management. Issues that they are seeking help with include: managing community volunteers; building and maintaining a management team; handling intergroup conflicts; handling role conflicts between professional, administrative-technical; handling labor management problems; managing conflicts of values; structuring organizations to support primary care delivery; managing interdisciplinary team delivery; handling the interfaces between the community, the primary care center, and the support hospital.

5.Delivery Team Leaders and Members

People who are in charge of care delivery teams, such as the team in a community health center, identify such issues as:

- How should the group make decisions about patient care strategies and tactics?

- Who on the team should provide what services?

- Under what conditions is the individual professional responsible to the team or responsible to his functional specialty?

- Which decisions should be made by the team and which by individual members?

- What content should be dealt with at team conferences?

6. House Staffs (Interns and Residents)

Currently identified issues include:

- How can they increase their influence on the learning environment?

- How can they get changes in traditional procedures introduced? For example, coordinating the care of a patient between intern, resident, attending physician, nurse, and social worker.

- How can they get some of their values (Example: doctor as healer) introduced into what is essentially a technological system?

7. Students

- How can they influence the curriculum and the teaching methods toward more "relevance"?

- How can they get more power in the system?

- How can they get more differentiation of curricula, depending on different learning needs? How can they loosen up the structure?

- How can they make medical education more human?

SO --- ?

With all these needs among health workers and health institutions, and all the resources in the behavioral science field, the obvious question is: "Why isn't more activity occurring?" "Why aren't more behavioral consultants located in health education and delivery

institutions, either as inside or outside resources?"

I believe the answers to these questions lie in a cluster of perceptions, defenses, traditions, and stereotypes that have resulted in attitudes of suspicion and resistance to collaboration by both health workers and behavioral science colleagues. Let me list a few:

From the point of view of health practitioners

- Behavioral scientists are soft and fuzzy -- it is not a real science.

- Behavioral science interventions consist solely of sensitivity training, group dynamics and other quasi-psychological techniques.

- Behavioral scientists aren't scientists -- they are missionaries trying to provide a humanized nurturing approach to everything.

- Behavioral scientists are too value oriented. They undervalue technology in clinical practice.

- Behavioral scientists are too process oriented. They don't seem interested in the task or mission of the organization, but only on how things are happening.

- Behavioral scientists don't understand the health world. Their experience is in industry where the goals are very clear -- making money; where the boss has clear control over his subordinates; where the products are tangible. That is a totally different world from the health world.

- Behavioral scientists are interested in change for change sake. The process of changing, itself, seems to be a worthwhile goal for them. Their effort is not related to the reasons for change.

- Behavioral science interventions might cause a loss of control from our point of view. We cannot afford this in a field which is a life and death profession.

- Behavioral scientists cannot communicate their knowledge practically. They are too theoretical -- too much jargon.

- Science values undergird the practice of medicine. Social values are a corollary. Our mission is to save lives, to increase technology and to maintain a high quality of care.

- Medicine is not egalitarian. Behavioral scientists try to influence us toward that condition.

- Behavioral science insights and practices are "old hat." There is nothing new. As health workers, we have been dealing with behavioral matters all of our professional lives.

- Our lives are filled with interaction with troubled people seeking help. We have developed our coping mechanisms for avoiding getting too involved in the emotional problems of our patients. Behavioral scientists are trying to change our coping mechanisms and reduce our "objectivity."

- We don't trust behavioral scientists. They have also developed their coping habits and facades and self-protective mechanisms. Are they practicing what they preach? We doubt it.

- Psychiatry is for doctors who couldn't make it in surgery and other more scientific professions.

- Psychiatrists seem outstanding among physicians for their lack of humility and caring. Do all behavioral scientists operate from "Don't do as I do -- do as I tell you"?

From the point of view of behavioral science practitioners

- We have a technology and skills in the areas of training, team building, individual counseling, etc. This technology can be applied to any setting including the health field. We are primarily technologists and transfers of technology.

- To be effective consultants, it is not necessary to know all about a particular field. Health organizations are composed of people, just like industrial organizations. We don't need a special orientation to the health field.

- We don't feel competent to work in the health field. It is too high a risk because they are dealing in matters of life and death.

- There is a lack of social values in much of the medical world. The concept of caring is totally alien to many health workers.

- We have a number of treatments, but we are not sure whether they fit the problems.

- It is very difficult to gain access to this system. It is full of resistance.

- We would not know where to begin.

- Medical people are over-concerned with professionalism. Doctors are more interested in our curriculum vitae than in our competence.

- The whole health system is controlled by doctors. They have their own goals, which may be science or money or both, but the system is not open to change.

- Why spend energy in such an autocratic system as a health delivery system?

- As long as doctors have the social status they do in our society and as long as the Medical Associations have the power they do in our government, we are really not going to change anything in the health field.

- The health system is a political football. The little bit of help we could give is meaningless in that giant system.

These are just a few of the more widely held stereotypes on each side that produce resistance to collaboration.

THE CHALLENGE

Given this paradox of high needs, increasing awareness of need for help, and high suspicion of behavioral scientists as helpers, where do we go from here?

I would suggest that interested practitioners would want to:

- Have a fairly clear picture of the health world -- the people -- the environment -- the current issues. It is not enough to say that all systems composed of people are similar and our technology and techniques are universally applicable. To work in this field, it is absolutely necessary, I am convinced, to understand alot about the field -- to be "in the heads" of its members

- Be prepared to provide both technology and personal investment of time and interest with the clients.

- Be prepared to start with a sceptical client system.

Let me next describe briefly a picture of the health world.

THE CURRENT ENVIRONMENT AROUND HEALTH CARE

I would suggest five categories in which this can be examined: values, political-economic conditions, management issues, delivery strategies, health education strategies.

Values

1. Increasing numbers of health workers are concerned with total care of a total patient -- as differentiated from specialized treatment of a specific malfunction.

2. There is an increasing trend toward helping patients manage their own health. This signifies a change in role emphasis for many health workers. It means developing more educational helping facilitative skills in addition to technical (treatment) skills.

3. There is a significant amount of energy being expended on improving the "caring" aspect of health care.

4. Community leaders are taking more active part in influencing the quality of health care in their communities. There is a growing body of people who are becoming activists in this area.

Political/Economic Conditions

1. Health care availability is very differentiated between geographic areas, economic populations, geographic relationship to universities and teaching institutions, etc. Although there is no total shortage of doctors in this country, there is a skewed distribution of health workers. This means that large segments of the population, particularly people in rural areas and in urban ghettos, are without adequate medical care.

2. Costs of health care continue to rise disproportionately to most other economic variables.

Delivery Strategies

1. New categories of health workers such as nurse practitioners, physicians' assistants, and family health workers are emerging to take

on some activities previously reserved for M.D.'s.[1]

2. The family, in many situations, is being seen as the patient unit rather than the individual. This is particularly true in comprehensive primary health care practice.[2]

3. Changing patient attitudes toward health workers is a conscious strategy of some organizations. Educating the family to accept as valid a physical examination by a member of the health team other than the doctor is seen as a difficult but necessary goal.

4. The role and functions of outpatient departments or clinics of hospitals is being enlarged. As hospitals are assigned a "catchment" area -- the potential patients in their community -- and the defining of patient populations becomes more specific (which will become a necessity under any national health plan), the outpatient department is increasingly called upon for a wider variety of services.

5. More and more delivery of primary health care is and will be done by interdisciplinary teams of health workers. These teams may be composed of only doctors and nurses, but in community situations they may be composed of doctors, dentists, nurses, social workers, family or community health workers, and sometimes, even lawyers.[3]

Education Strategies

1. Most faculties of medical, nursing, dental and other health institutions are actively considering major curriculum revisions at this time. These include changes not only in focus and content, but also in faculty/student relationships, methods of teaching, environments for teaching, cross-school collaboration.[4] Organization psychologists and educational psychologists can be of significant help in this area.

2. There is an increasing exploration of the part of curriculum planners of what kind and how much behavioral science content should be included in medical and other health school curriculum.

3. There is pressure for more differentiation in learning environment. For example, a major effort is underway to explore whether the teaching of primary care content should be [can] interdisciplinary learning team or class from a variety of health schools.[5]

4. There is a strong and growing movement among students and among various advocacy groups for increasing the numbers of women and minority groups in medicine and for providing better and more equal job opportunities for women in this field.[6]

Management Issues

1. The necessity for systematic planning systems to cope with complexity is becoming increasingly apparent to institutional leaders.[7]

2. The traditional independence and identity -- and hierarchy -- of the different health schools in the university: medicine, nursing, dentistry, allied health -- is being crossed. New administrative forms are emerging which change the relationships between these various schools. In many schools there is now a Vice President of Health Affairs. This role is administratively responsible for all of the health schools. This changes the roles and responsibilities of the dean of the Medical School, the dean of the Nursing School, etc.

3. In many schools, organization forms and structures are being reexamined [are new patterns are] emerging.[8]

4. There is an increasing desire among health leaders for management knowledge and skills.[9]

5. There is a growing need and an awareness of the need for understanding individual, group and organization change.

6. Problems of intergroup and interinstitution collaboration in conflict management are very much recognized. New patterns of inter-agency relationships within universities and between schools and hospitals require high degrees of skill in managing intergroup relationships.

7. The overlapping roles of people in key positions such as the head of a clinical department in a medical school and chief of services in a hospital, increase the complexity of organizational decision making and communication.

8. The management of resistance to change is a key issue for health administrators. The conflict between the changing values toward a more humanistic approach toward delivery of health care, and the strong values of science held by a majority of the medical people, require creative management. The medical profession is traditionally an autocratic technological profession. It is having to face a whole new set of forces toward people-oriented care. At the same time, there is a continuing need for maintaining high level basic research. This is a complicated management problem.

9. The high political potency of health means that there is continuing and complex governmental intervention.

10. It is clear that the trend in the health field is toward more linkage: between users and health care deliverers, between delivery and educational institutions, between faculties and administration, between schools and hospitals and between national institutions.

OUR RESOURCES

To provide this linkage, we have technology, skills and ourselves. Let me look briefly at these.

Technology

The principal areas of content from the behavioral sciences that seem to be called for are:

1. Organization behavior and processes;
2. Individual and group dynamics;
3. Management and leadership;
4. Planning and managing change;
5. Community development, power, political behavior.

The principal applications are to problems of managing complex organizations; coping with environmental change; building more effective teams; increasing interpersonal competence; developing better learning environments; humanizing the delivery of care; strategic planning.

Personal

I want to emphasize strongly the importance of the personal investment of the helper in the health system. In my experience, there is a very high need for this investment.

The mode of "professional distance" which is appropriate to much counseling and consulting tends to be less appropriate in this setting. This is in spite of the fact that health leaders are deeply concerned with "professional" qualifications and behavior.

The doctor-patient model, which governs much of the traditional thinking, is, generally, a prescription model. So it is common to find clients wanting prescriptive answers to their problems (not very different from other settings). What is more unexpected is the heavy need for personal contact with the helper -- almost as a transference of the doctor-patient role -- to that of the healer of the organization.

At the same time, the problems of entry and acceptance by the system tend to be more difficult, and require more investment than in other systems. Rubin, Plovnick and Fry's experience in the companion article will illustrate this point in more detail.[10]

A Few Case Illustrations

I would like to give a few examples to illustrate these points.

1. In collaboration with the Association of American Medical Colleges, the Sloan School of Management, M.I.T., is conducting a one week "music appreciation" course in management for Deans of academic medical centers, who have expressed needs for more management skills in leadership, planning, conflict management, team development, organization design, and decision making. A number of Sloan School faculty participate in the course. The two faculty coordinators make it a point to attend and participate in each session, with the mission of providing linkage between the M.I.T. faculty and the Deans (whose needs and requirements we have come to know). In the evaluation of the course, deans consistently comment on this behavior. There have been a number of comments that this is perhaps one of the most useful and helpful aspects of the whole experience. It is often expressed: "The important thing is that the faculty cares enough to sit with us throughout the program."

2. Following up this one week course, the AAMC conducts an Organization Development and Planning workshop for interested Deans. In these workshops, the dean brings to a four day meeting a "critical mass" of his colleagues and/or bosses to work on an organization problem which he has identified. Sample problems are:

- "What should be the new structure of the medical center -- vis a vis the schools, the university hospital, the private hospitals?"
- "We now have a vice president for health affairs. How shall we structure the leadership of the health sciences schools? Should there be a team of vice presidents and deans of schools?"
- "We are going to become more of a community relevant institution. We are going to increase the priority of primary ambulatory (non-hospital) care. How can we modify our focus and still maintain a top quality basic research and scientific capability?"

The "teams" at these workshops are assisted by management and behavioral science consultants. Eighteen schools have participated in this activity, and another thirty schools are "waiting their turn."

Where teams have perceived their consultants as really helpful (and frequently developed ongoing relationships with them), the participants have specifically commented on the consultants' personal investment in them -- availability outside formal meetings; personal concern and caring for the individuals on the team; attention to process.

3. Several of us from Sloan have been working for a number of years with the Martin Luther King, Jr., Health Center in the Bronx, New York. Much of the work has been with the delivery teams -- inter-disciplinary teams composed of doctors, nurses, family health workers

(local residents with some specialized training), backed up by other doctors, dentists, and even lawyers. In practically every contact with these teams, members have reacted positively or negatively, but always primarily to the personal behavior of the consultant. It seems that the personal interest of the consultant is an essential condition in the early stages of this type of relationship.

4. In Rubin's, Fry's, and Plovnick's work in developing self managing learning packages for interdisciplinary delivery teams, they have found that regardless of the quality of the content and the helpfulness of the methods -- that without the personal contact with the consultants, there is high resistance to "getting started."

5. I have been working with a group of twenty-five organization leaders (roles such as hospital director, medical director of community health center, director of community nursing at graduate nursing school, director of clinics, director of outpatient delivery team) on developing educational interventions to help people like themselves be better able to manage change in their institutions.. After participating as students in a course with me, they are now engaged in developing experiments for applying "educational interventions" in their settings. Currently we have, for example, introduced change content into a curriculum planning course to compare output with the more traditional course. We are tracking a nursing school whose faculty are implementing a totally new curriculum based on primary family oriented care -- with a new teaching mode (team). We will introduce a program on change skills

to a similar faculty with a similar curriculum change and we will track both for effectiveness. Content on change management is being experimentally introduced into the training programs for head nurses at two hospitals. The medical and administrative leaders of two merging health centers are jointly involved in a change management course.

In all these experiments, continuing close personal involvement has been a common requirement.

INITIATING ACTION

What are some "next steps" for the interested practitioner?

I would suggest the following:

Look Around

- Look in the community at community health centers and at departments of community medicine in medical schools.

- Look in the university. Where is a new curriculum being considered? What help could you provide?

- Look at the management of the health schools. Is there a reorganization? -- a reallocation of responsibilities? Can you help?

Be Aware

The following guidelines have proven useful in my work:

1. Recognize the readiness for help.

2. Recognize that the readiness may be masked by suspicion of your competence and/or relevance.

3. Recognize that there are many negative role stereotypes, traditions and perceptions that have to be broken through.

4. Recognize that you may have some perceptions that need changing. If your attitude is: "Look...there's enough to do...Why work with 'non-ready' clients?"...this is not the place for you.

5. Recognize that one of the relationship problems is that most health workers see themselves as helpers...just as do most behavioral scientists. Helpers have more difficulty than anybody in receiving help.

6. Recognize that for many health workers, behavioral science means psychiatry or animal behavior or clinical psychology -- not much to do with managing complex institutions.

7. Recognize the need to develop a problem oriented or task oriented approach rather than a discipline oriented one. Alot of confusion has existed from the perception of some health workers that we are trying to induce our solutions into their world. We need to start from the point of the client's perceived problem. Medicine itself is moving, albeit slowly, from a mode of treatment of specific symptoms to a total patient problem oriented approach.

8. Develop an active program of learning about the health world. This may mean spending time in health institutions, just learning "how it ticks." Dilemma: Is this "professional" time? Should you be paid for it?

9. Recognize the strong trend toward "professionalism" in the field. The majority of clients have had specialized training and certification. They are very oriented toward this -- particularly with the emergence of "para" professionals. Equating of credentials and competence is common. It is understandable that the same "norms" would be applied to us.

10. Recognize the high, but masked, need for personal support.

IN SUM

I've said:

"There's a market out there. They need us."

"They know they need help, but they're not sure we have it."

"They're suspicious of what they think behavioral scientists are and do."

"We have a few hang-ups and stereotypes to bury."

"Our 'know-how', our personal values toward collaboration, and our interest in joint outcomes are equally required."

"There's a great opportunity to make a significant difference in the quality of life and health, if we go after it."

I hope more of us do...

REFERENCES

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[1]There are a number of certificate and diploma courses now offered for physician's assistants.

[2]This orientation governs many new curricula. For example, University of Massachusetts and Boston College nursing curricula have this as a major focus. Experimental curricula, being developed by the Institute for Health Team Development at Montifiore Hospital, New York, focus on interdisciplinary learning across schools, learning to treat families in primary care.

[3]See Beckhard, "Organizational Issues in the Team Delivery of Health Care," Millbank Quarterly, 1972.

[4]Several of the projects on change management at M.I.T. focus on this area.

[5]See Note #2, Institute for Health Team Development.

[6]Efforts are underway to formalize an Institute for Women in Medicine. There is already a task force in this field working on this. For details, contact Ms. June Taylor, Coordinator, Task Force on Women, Health, and Human Values, c/o Board of Christian Education, United Presbyterian Church, Philadelphia, Pa.

[7]The AAMC Advanced Management Program is designed to meet this need. Seventy-five of the one hundred-fourteen medical school deans have already participated.

[8]See "A Study of Academic Medical Centers," Paul Lawrence, et al., Harvard Business School, 1973.

[9]See Note #7.

[10]The article appears in this issue of JABS.

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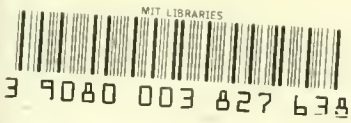

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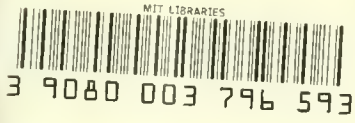

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